**PATIENT NAME** _____ **DATE OF BIRTH** _____ **ID#** _____

**SS#** _____ **SEX** _____ **RACE** _____

**PLEASE FILL OUT THE FOLLOWING FOR THE PERSON RECEIVING DENTAL CARE**

## PART I - GENERAL INFORMATION

DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE NO. HOME _____WORK/EMERGENCY NO. _____

PARENT/GUARDIAN NAME _____

WHO WILL PROVIDE TRANSPORTATION TO CLINIC? SELF _____ PARENTS _____ SCHOOL _____OTHER ____

HAVE YOU BEEN TO A DENTIST BEFORE? YES ____ NO ____

IF YES. WHERE? _____ WHEN? _____

DO YOU PRESENTLY HAVE A MEDICAID CARD? YES ____ NO ____ MEDICAID # _____

HAVE YOU BEEN CERTIFIED AS ELIGIBLE FOR OTHER HEALTH DEPARTMENT SERVICES?

YES ____ NO ____ IF YES. WHEN? _____

HAVE YOU EVER RECEIVED DENTAL SERVICES AT THIS CLINIC? YES ____ NO _____

IF YES. WHEN? _____

## PART II- PERMISSION

**DENTAL TREATMENT MAY INCLUDE EXAMINATION. X-RAYS, CLEANING, TREATMENT OF GUM DISEASES, FLUORIDE AND SEALANT APPLICATIONS AND FILLINGS USUALLY WITH LOCAL ANESTHESIA. IF THE CAVITY IN THE TOOTH IS VERY DEEP AND THE NERVE AND BLOOD SUPPLY ARE AFFECTED, THE REMOVAL OF THE NERVE OR THE TOOTH, USING LOCAL ANESTHESIA, MAY BE NECESSARY. PROBLEMS ARISING FROM DENTAL TREATMENT ARE VERY RARE. THE PUBLIC HEALTH DENTIST WOULD LIKE TO PROVIDE YOU WITH COMPLETE INFORMATION REGARDING THE RISKS AND BENEFITS OF YOUR OR YOUR CHILDS DENTAL TREATMENT. I UNDERSTAND THAT IF I CANNOT COME WITH MY CHILD TO THE DENTAL CLINIC, I MAY CALL THE PUBLIC HEALTH DENTIST DURING REGULAR WORKING HOURS TO DISCUSS MY CHILDS TREATMENT.**

I GIVE INFORMED CONSENT FOR MYSELF OR MY CHILD TO RECEIVE DENTAL TREATMENT AS PRESCRIBED BY

THE DENTIST. YES ____ NO _____

I GIVE CONSENT FOR MY CHILD TO BE TRANSPORTED TO AND FROM THE DENTAL CLINIC. YES _____ NO _____

THE **INFORMATION GIVEN IN PART I, II, AND III** OF THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE OR BELIEF.

**DATE** _____ **SIGNATURE** _____

(PATIENT. PARENT OR GUARDIAN)

DOCTOR'S NOTES OR ADDITIONAL INFORMATION: _____

MEDICAL HISTORY UPDATE

**DATE** |_____|_____|_____|_____|_____|_____|

**SIGNATURE** |_____|_____|_____|_____|_____|_____|

**PATIENT NAME _____ DATE OF BIRTH _____ ID _____**

## PART III - HEALTH HISTORY

**PLEASE CHECK YES OR NO BESIDE ALL OF THE FOLLOWING. FOR THE PERSON RECEIVING DENTAL TREATMENT.**

1. ARE YOU IN GOOD HEALTH? IF NOT, PLEASE EXPLAIN_____ YES_____ NO_____

2. ARE YOU NOW BEING TREATED BY A PHYSICIAN FOR ANY CONDITION? IF YES. WHAT? YES_____ NO_____
_____

DOCTOR'S NAME _____ DATE OF LAST PHYSICAL
_____

3. ARE YOU TAKING ANY PRESCRIPTION OR NONPRESCRIPTION MEDICINES OR DRUGS ? YES_____ NO_____

IF YES. WHAT? _____ HOW OFTEN? _____

4. ARE YOU ALLERGIC TO ANY MEDICINES. POLLEN. OR FOODS? YES_____ NO_____

*5.* HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU ARE ALLERGIC TO OR SHOULDN'T TAKE PENICILLIN? YES_____ NO_____

6. HAVE YOU EVER HAD A REACTION TO A DENTAL INJECTION? YES_____ NO_____

*7.* DO YOU HAVE A HISTORY OF FAINTING? YES_____ NO_____

8. HAVE YOU HAD A WEIGHT CHANGE RECENTLY? YES_____ NO_____

9. DO YOU USE TOBACCO PRODUCTS? IF YES. WHAT?_____ YES_____ NO_____

10.HAVE YOU HAD CANCER. LEUKEMIA. OR A TUMOR? YES_____ NO_____

11.HAVE YOU EVER HAD RADIATION THERAPY? YES_____ NO_____

12.DO YOU HAVE ASTHMA. A RESPIRATORY PROBLEM. OR USE AN INHALER? YES_____ NO_____

13.ARE YOU PREGNANTIBREASTFEEDING7 YES_____ NO_____

14.HAVE YOU EVER RECEIVED BLOOD PRODUCTS OR A BLOOD TRANSFUSION? YES_____ NO_____

15.HAVE YOU EVER TESTED POSITIVE FOR HIV/AIDS? YES_____ NO_____

16, HAVE YOU HAD OR DO YOU NOW HAVE HEART DISEASE? YES_____ NO_____

| | | | |
|---|---|---|---|
| • HEART VALVE REPLACEMENT? | YES_____ NO_____ | •RHEUMATISM OR ARTHRITIS? | YES_____ NO_____ |
| • HEART MURMUR? | YES_____ NO_____ | • ANY JOINT REPLACEMENT? | YES_____ NO_____ |
| • CHEST PAIN WHEN EXERCISING? | YES_____ NO_____ | • SEXUALLY TRANSMITTED DISEASES (GONORRHEA. SYPHILIS. HERPES)? | YES_____ NO_____ |
| • UNUSUAL SHORTNESS OF BREATH? | YES_____ NO_____ | • GOITER. THYROID. OR GLANDULAR PROBLEMS? | YES_____ NO_____ |

| | | | |
|---|---|---|---|
| • HIGH BLOOD PRESSURE? | YES_____ NO_____ | • HEPATITIS (LIVER PROBLEMS)? | YES_____ NO_____ |
| • RHEUMATIC FEVER? | YES_____ NO_____ | • KIDNEY PROBLEMS? | YES_____ NO_____ |
| • ANEMIA? | YES_____ NO_____ | • MENTAL DISORDERS? | YES_____ NO_____ |
| • TUBERCULOSIS? | YES_____ NO_____ | • SEIZURES? | YES_____ NO_____ |
| • DIABETES? | YES_____ NO_____ | • BLEEDING DISORDER OR BLEEDING TOO LONG AFTER AN EXTRACTION? | YES_____ NO_____ |

17. DO YOU HAVE ANY ALLERGIES TO LATEX? YES_____ NO_____